MARYLAND FAMILY RESOURCE, INC.

Psychiatric Rehabilitation Program (PRP) Referral Form - Adults

Date of Referral: _____ Referring Clinician: _____
Agency Address & Phone Number (If External):

Consumer's Name: _____ DOB: _____ Age: _____
Gender: _____ Preferred Pronoun: _____ Race: _____
Address: _____
_____
Phone: _____
MD Medicaid ID: _____

Mental Health Diagnosis: _____

Parent/Guardian (if applicable): _____

Relationship to Consumer: _____

For the following questions, please indicate "Yes" "No" or "Unknown"

1. Is this consumer currently enrolled in SSI/SSDI? _____
2. Is this consumer eligible for fully funded Developmental Disabilities Administration Services? _____
3. Is the primary reason for the participants' impairment due to an organic process or syndrome, intellectual disability, a neurodevelopmental disorder or neurocognitive disorder? _____

Please indicate at least 3 areas of functional impairment and use the space below to provide details:

1. Marked inability to establish or maintain competitive employment
2. Marked inability to perform instrumental activities of daily living
3. Marked inability to establish/maintain a personal support system
4. Deficiencies of concentration/persistence leading to failure to complete tasks
5. Unable to perform self-care (nutrition, medical care, safety)
6. Marked deficiencies in self-direction, shown by inability to plan, initiate, organize and carry out goal directed activities
7. Marked inability to procure financial assistance to support community living?

_____
Referring Clinician Signature/Credentials

** Please Submit form via email to Patricia Sanyer psanyer@mfrinconline.com or Fax to 301 333 8161 **